STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155795	A. BUILDING _____ B. WING _____	R-C 03/31/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON SPRINGS HEALTH CAMPUS	**2400 SILHAVY ROAD VALPARAISO, IN 46383**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for the PSR (Post Survey Revisit) to the Investigation of Complaint IN00166926 completed on 02/24/15.

This visit was in conjunction with the Investigation of Complaint IN00168914.

Complaint IN00166926-Corrected.

Survey date: March 30 & 31, 2015

Facility number: 012766
Provider number: 155795
AIM number: 201051640

Survey team:
Regina Sanders, RN, TC

Census bed type:
SNF: 36
SNF/NF: 20
Residential: 57
Total: 113

Census payor type:
Medicare: 26
Medicaid: 16
Other: 14
Total: 56

Sample: 5

Avalon Springs Health Campus was found to be in compliance with 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00166926.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Quality review completed on April 5, 2015, by Janelyn Kulik, RN.	{F 000}		